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News: Hewitt's husband objects to 100-hour pharmacy opening

News: Boots Viagra pilot sparks calls for easier PGD sign-off

Features: Take a trip to Phoenix with Paul Smith and David Cole

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Pharmacy Champions

Cover: This week's Pharmacy Champion, Ravi Mohan. Picture: Rod Leach Photography

Hewitt's husband against 100-hour pharmacy

Exclusive MP's spouse joins campaign against proposed 100-hour pharmacy

Max Gosney

Patricia Hewitt's husband has backed a campaign to block a pharmacy opening under the control of entry exemptions.

William Birtles is calling on Camden PCT to reject a 100-hour opening by ABC Pharmacy, C+D can exclusively reveal.

Ms Hewitt, secretary of state for health, announced the control of entry measures in her previous post as secretary of state for trade and industry in 2003.

ABC Pharmacy stressed it opposed the 100-hour exemption in principle, but had decided to apply under the rules to meet patient need.

"I write to oppose the opening of the new pharmacy at NW1 and in particular the control of entry exemption for it," Mr Birtles said in a letter to Camden PCT.

The comments came as part of a bid by local residents to block the application. They claim the proposed pharmacy could attract drug users to the area with plans for a needle exchange service and force the nearby Biotech pharmacy out of business.

"The area is already well served by the Biotech pharmacy. I would hate to see such an integral part of our community run out of business. I believe the remit of the new pharmacy will be a needle exchange service. This will undoubtedly attract drug users and dealers," said a Camden resident.

Exemptions forcing PCTs to act independently of the interests of the local community "need to be looked at", Mr Birtles told C+D.

ABC Pharmacy also criticised the current control of entry exemptions. Managing director Nick Beilby said: "I think the 100-hour exemption is a bad idea because it takes away the decision-making process from PCTs. But, in this instance we have decided to apply because there's going to be a temporary move of patients to the area while a nearby health centre is redeveloped."

Hewitt: relaxed pharmacy opening rules

Camden PCT said the 100-hour pharmacy application will be reviewed this week. Under NHS regulations approval of the application is 'automatic', according to the PCT. There are currently two pharmacies providing needle exchange in the area and one fifth of pharmacies in Camden offer this service, the PCT added.

Biotech pharmacy owner Hansila Vaghela said: "There's no need for two pharmacies here. I've lived in the area for 23 years and I'm happy serving the local community."

Patricia Hewitt was abroad and unavailable for comment as C+D went to press.

Residents say existing pharmacy serves their healthcare needs

News in brief

Everything calm, claims Alliance Boots

Alliance Boots has rejected reports of a dispute with suppliers as it attempts to reduce supply chain costs following its £7 billion merger with Alliance UniChem.

"The majority of suppliers have engaged in constructive discussion," an Alliance Boots spokesperson said in response to reports in the Sunday Times newspaper of a rift.

Boots said it was confident of securing renegotiated terms with all its suppliers. "We have been upfront and made it clear since the merger we would be seeking the best price. Nobody has threatened to stop supplying on this issue," the spokesperson added.

Boots could cut suppliers fees by between 8 and 15 per cent, according to the Sunday Times.

Boots supplies Viagra under PGD

Multiples Cut regulatory burden to make PGD process easier, says NPA

Wesley Yin-Poole

A Boots pilot to provide Viagra over the counter through the patient group directive scheme has sparked calls to make the process easier for all pharmacists.

Pharmacy stakeholders are set to lobby healthcare regulators over "barriers" to widen PGD access following Boots' move to supply the drug for erectile dysfunction.

Stephen Fishwick, head of NHS service development at the NPA, said: "We're already in the process of speaking to the Healthcare Commission, with a view to arriving at a common understanding of a possible way forward to reduce the regulatory burden. The news from Boots was a prompt for discussion."

Boots pharmacists will offer Viagra to men aged 30 to 65 in three Manchester stores under the pilot.

The service follows Boots PGDs to provide prescription drugs as part of weight and hair loss clinics over the past two years. However, excessive red tape is restricting opportunities for other pharmacists to follow suit, said the NPA.

"The process of registration is time consuming and costly, effectively gating out some providers. NPA members are telling us that when they try to innovate using this route they are stymied at the first hurdle," a spokesperson told C+D.

Boots said its Viagra pilot had been realised as a result of careful research. Kevin Reilly, pharmacy development manager at Boots, said: "This pilot was very, very challenging. It is fortunate we have the capacity to do that but we take all of the accountability. It's taken us a lot of time – we've been working on shaping this for two years."

Pharmacists will invite patients to undergo a detailed consultation and health check as part of the Viagra PGD service, according to Boots. The scheme will cost £50 for the initial screening and supply of four tablets.

Following the first pharmacy consultation, the customer will be advised to book a follow-up with a Boots-nominated private doctor before further supplies can be made.

How do you set up a PGD?

The Healthcare Commission charges £907 for registration, and say it takes approximately three months to approve. A spokesperson said: "Clearly the legal position currently requires registration with the Healthcare Commission, which has a required cost and time factor, but we certainly do not want to create unreasonable barriers to market entry. We would be happy to discuss with the NPA or others how the process could be streamlined while maintaining proper safeguards."

News in brief

Learn with NPC Plus

C+D has joined forces with the National Prescribing Centre to help pharmacists with their CPD.

Cardiovascular risk and respiratory disease workshops take place in Manchester on March 13, Leeds on March 15 and Warwick on March 20. Numbers are restricted so book early. Phone 01732 377269 or see page 16 for details.

Control of entry changes

A double change to control of entry will be put out to consultation by the end of this month, C+D understands. The review will propose charging for pharmaceutical applications and tighter guidelines to help PCTs make the correct choice when faced with multiple applications, according to a source.

Section 60 approved

The Section 60 Order has been approved by Parliament. Replacing the Pharmacy Act 1954, the Order has reformed the Society's registration process, including the statutory registration of pharmacy technicians in England and Wales; updated provisions for education, training and CPD; and obliges the Society to inform PCTs and employers when an allegation against pharmacists is referred to a fitness to practise hearing. An amending order is planned for later this year to extend the arrangements to pharmacy technicians in Scotland.

NCSO update

The DH and the National Assembly for Wales have agreed to allow NCSO endorsements for the following items for February 2007 prescriptions – ketoprofen capsules 100mg, bisacodyl tablets e/c 5mg, diamorphine injection ampoules 5mg, diamorphine injection ampoules 100mg, diamorphine injection ampoules 500mg.

Pill OTC popular

Pharmacists have voted overwhelmingly in favour of selling the Pill OTC in an online C+D poll.

Just under 60 per cent of respondents would like to see the Pill go OTC, according to the poll. Don't miss C+D's online feature on POM to P switches this week. www.dotpharmacy.com

Cut it out: Superdrug deposited 25 life-size cutouts of Chancellor of the Exchequer Gordon Brown on the Treasury's doorstep this week. The cutouts spent the previous week collecting more than 1,000 customers' signatures for a petition calling for an end to taxes on suncreams for children

King's Fund survey finds PCTs ignoring APMS opportunities

Policy Volume of alternative providers in primary care remains small

Emma Wilkinson

PCTs are failing to use alternative providers such as community pharmacies for primary medical care services, a report from the King's Fund suggests.

A survey of 122 PCTs showed the volume of alternative providers in primary care remains small and use of APMS contracts is limited.

Only two PCTs had awarded a contract outside the 'NHS family'.

Most PCTs were using APMS contracts to fill long-term practice vacancies, the majority of which had been filled by local entrepreneurial GPs.

The King's Fund team said PCTs were being cautious in commissioning alternative types of primary care provider from the commercial sector, with GPs having a 'virtual monopoly'.

They added that NHS managers may not have the knowledge or the courage to challenge local GPs.

Dr Nicola Walsh, visiting fellow at the King's Fund, said they would be looking in detail at the reasons for the findings.

"For 50 years, we have always relied on NHS providers. Like all things, we have to get a shift in mind set to think about diversity of provision."

In evidence to the Galbraith review into control of entry, the Company Chemists' Association also warned there needed to be more contestability in primary care service provision, in particular for enhanced services, with funding streams opened up.

A spokesperson for the CCA said: "PCTs have unprecedented opportunity and freedom to encourage new providers and to think creatively.

"But as well as overcoming the financial barriers, there is huge cultural change needed. Pharmacy is a safe pair of hands. The time is right for pharmacy to deliver."

Stephen Fishwick, head of NHS service development at the NPA, said there had been a 'double whammy' of financial problems and PCT reorganisation, which had prevented pharmacy commissioning moving forward.

"What we don't want to happen is a triple whammy of poor governance that results in perpetuation of a GP monopoly," he added.

For more information go to www.kingsfund.org.uk

How pharmacy has fared under PCT commissioning

We didn't have success with the five PCTs in Leeds but that was financial. It's looking much more promising now we have gone to one PCT and we're really quite hopeful that they are looking to supply different types of services.
Janet Ward, LPC secretary, Leeds

The uptake has been relatively small. The profession has failed to convince the commissioners of the value. It's a major frustration and it's something the LPCs are increasingly having to get to grips with. What we need to do is present more business-like proposals to PCTs.
Gareth McCague, LPC secretary, Leicester

News in brief

Canesten AF switch?

Bayer Consumer Care is seeking a P to GSL switch for Canesten AF Bifonazole Once Daily Athlete's Foot Cream.

Bifonazole 1 per cent cream has been licensed in the UK since 1986 as a treatment for athlete's foot, with subsequent reclassification to a P medicine in 1997.

The MHRA is inviting comments, to be returned by March 26 on its website at www.mhra.gov.uk

Day Lewis rebrand

Pharmacy staff are taking time out to help Day Lewis rebrand six Boots stores in 36 hours. The project follows Day Lewis's recent acquisition of 31 pharmacies from Alliance Boots.

Day Lewis is also planning seven roadshows to help the 250 Alliance Boots staff integrate into the company.

Pharmacy goes forth

Pharmacy services will be included as part of a £300 million investment in a community hospital and replacement Alloa Health Centre for Clackmannanshire in Scotland.

NHS Forth Valley is looking to develop an integrated model of care and provide a combination of new pharmacy contract and specialist pharmacy services.

The hospital will incorporate three GP practices, which are moving from the present Alloa Health Centre.

Welsh IT claims

Pharmacy contractors in Wales must fill out and submit a copy of the ETP1 claim form to ensure their payment for connectivity.

The new requirement was announced by the WAG Primary Care IM&T. BSCs will be contacting contractors and distributing the form, which is available on the PSNC website, www.psnc.org.uk

Drug advice for CVD

A BMJ review of safety monitoring and testing of the cardiovascular drugs amiodarone and digoxin has concluded that blood levels often do not correlate with activity or toxicity. The author added that therapeutic ranges are guides only, and that prescribers should know how to use them.

'Join the NHS team'

Politics Contractors urged to abandon old rivalries with GPs

Max Gosney

Think as a team rather than as individuals if you want to thrive in the NHS of tomorrow, a senior government policy advisor has told MPs investigating the future of pharmacy.

Contractors must abandon old rivalries with GPs and get proactive under practice-based commissioning, Dr David Colin-Thomé urged the All-Party Pharmacy Group at Westminster last week.

"We need a shift in mind set. It's the idea of thinking as an organisation. Sometimes professions are saying 'why am I not engaged?' rather than 'what more can I be doing?' I think that is one of the issues here," he said.

Dr Colin-Thomé pleaded for pharmacists to give GPs time to get on top of PBC. "I think GPs need time to adjust from the idea of doing everything themselves to using other healthcare professions to best manage community care. There's a role for pharmacy, but the profession needs to be pushing for it," he added.

Dr David Colin-Thomé: calling for a shift in mind set

Pharmacists must look to "collaborate rather than compete" with other NHS stakeholders, said England's chief pharmaceutical officer Keith Ridge. "This is about the maturity of professions being able to work together under a culture of collaboration," he said.

The APPG is due to report on the findings of its inquiry into the future of pharmacy this spring.

GP incentives praised

Calls for GPs to be given cash incentives to commission pharmacy services under practice-based commissioning have been backed by the APPG chair.

Offering incentives to doctors is the only way to ensure pharmacy is at the forefront of commissioning plans, said APPG chairman Howard Stoate.

"GPs need to be given incentives to get them to work. It's had an amazing effect under their new contract," he said.

The comments follow calls from the Company Chemists' Association to introduce closer ties with pharmacists under the GP contract.

However, primary healthcare tsar David Colin Thomé expressed reservations over the proposal. "There will be tension if you have quality and outcome frameworks in both GP and pharmacy contracts," he said.

Is pharmacy stuck on the NHS sidelines? Have your say by contacting Max Gosney on 01732 377315 or email mgosney@cmpmedica.com

TV and film documentary maker Michael Moore chats with pharmacist Dilip Soshi, of the Boss Pharmacy, Clapham, while making a new documentary this week

News in brief

GP errors under scrutiny

The General Medical Council is to invest £100,000 in a study of the prevalence and causes of doctors' prescribing errors. A working party will also explore ways to improve prescribing. The moves follow press allegations that changes in pharmacology teaching had led to errors.

Hewitt backs enhanced services

Politics Minister praises pharmacists' efforts to combat chronic diseases

Health minster Patricia Hewitt has reiterated the government's intention for pharmacists to take a greater role in treating chronic diseases during a webchat this week.

Ms Hewitt was asked how she planned to use pharmacists to counter an epidemic of "lifestyle diseases". She said that pharmacists were already offering a lot more services such as stop smoking services and medication reviews.

She added: "More and more are installing small consulting rooms so they can give advice and immediate treatment.

"In London, we've been trialling chlamydia screening in Boots – which is working really well with young women, though it's a problem getting young men in.

"And we certainly intend to do more, because it works so well for patients." **EW**

OFT drugs pricing report expected this month

Industry Report could recommend pricing medicines against benefits delivered

Emma Wilkinson/Max Gosney

The Office of Fair Trading investigation into the scheme that sets profit levels for manufacturers of branded pharmaceuticals may be published this month, according to the competition watchdog.

"I'll stick my neck out and say it will probably be published this month but we can't guarantee it," an Office of Fair Trading spokesperson told C+D.

The report on the Pharmaceutical Price Regulation Scheme (PPRS) could see medicines priced by the benefits delivered to the NHS, according to an article in the Financial Times newspaper.

Introducing "value-based" pricing will make it harder to bring medicines to market, said Elisabethann Wright, counsel at law firm Hogan & Hartson. "Demonstrating added value can be a challenge as it is difficult to identify a suitable comparator between a product that has been on the market for a number of years and a new product which, although it comes with high expectations, does not yet have tangible proof of quality, safety and efficacy."

The Association of British Pharmaceutical Industry said: "We have been involved in lengthy discussions with the OFT. We await publication of the report with interest and hope the welfare of patients is top of the agenda."

News in brief

Good CD practice guide

A new edition of A Guide to Good Practice in the Management of Controlled Drugs in Primary Care (England) has been published by the National Prescribing Centre. It is available online at http://tinyurl.com/ynjqr8

Blockbuster double

Two blockbusting drug launches for the treatment of hypertension and wet age-related macular degeneration were announced by Novartis this week.

The amlodipine-valsartan treatment (Exforge) is indicated for patients whose blood pressure is not adequately controlled on amlodipine or valsartan monotherapy.

Ranibizumab (Lucentis) for the treatment of macular degeneration binds to factors believed to cause endothelial cell proliferation and neovascularisation.

Patient pleasing

The NPA is offering to help its members complete the mandatory patient satisfaction survey, due in March 2008.

A resource pack and two survey companies will be on hand to help.

Raina Jordan, NPA commercial manager, said: "If you would like advice on which level of support may be best for your needs or to register your interest in readiness for the announcement, please contact us on r.jordan@npa.co.uk"

Top dog: this canine mascot will visit 40 West Midlands primary schools as part of a healthy eating initiative by The Midcounties Co-operative pharmacy group. Healthy Hound was pictured at Berrybrook Primary School in Wolverhampton. Government figures show 8.5 per cent of six-year-olds are clinically obese

Independent prescribers 'new arm for NHS' in Wales

Wales Pharmacists and nurses complete training

One hundred and fifty independent prescribers will be operating in Wales by this autumn when their training has been completed as the first stage of providing a new arm for the NHS.

The 150, a mix of pharmacists and nurses who currently hold supplementary qualifications, will have been "prioritised according to local need" by local health boards and NHS trusts for attendance at conversion courses in Wales.

First minister Rhodri Morgan described the change as "by far the biggest change in the role of pharmacists" in improving healthcare.

Combined with the advent in April of free prescriptions, the profession "will no longer be revenue collectors; instead they will be able to devote more time to this prescribing and advisory role". **CB**

RPSGB president on increasingly innovative roles. See p11 ›

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News in brief

If you don't ASK

Two pharmacies are among 20 successful applicants to receive ASK grants, organised by Ask About Medicines in partnership with Merck Sharp & Dohme.

GR Pharmacy in Birmingham and Brights Chemists in Nuneaton have each been awarded £1,000 to spend on activities to support Ask About Medicines Week.

The grants cover activities taking place between Ask About Medicines Week 2006 and the 2007 event, which runs from November 5 to 9.

Physio appointment

A chartered physiotherapist will become the Department of Health's chief health professions officer for England on March 1.

Karen Middleton, who has been acting chief health professions officer since January, will work closely with allied health professional advisors to develop local, integrated and patient-centred services. Ms Middleton has been health professions advisor at the DH since March 2003.

Rubber stamped: public health minister Caroline Flint checks in on a sexual health campaign at a Co-op pharmacy in Rossington. Ms Flint (centre) joins, from the left: pharmacist Osman Ali and colleagues Louise Tranter and Kelly Gallagher at the pharmacy. The team is championing the Department of Health's campaign to take the stigma out of buying condoms

News in brief

Global partnerships

Pharmacists and other health professionals could make an important contribution to health in developing countries, a report by Lord Crisp, former chief executive of the NHS, has said.

Global Health Partnerships makes 16 recommendations, including piloting a global health exchange, which could be used to match requests for equipment, books, work experience and disaster relief with offers. For more information go to www.dh.gov.uk

Owing period

A Royal Pharmaceutical Society Law and Ethics bulletin has clarified that the six-month validity period for an owing for a P or GSL medicine is not a legislative requirement but a professional one.

However, where a P or GSL medicine is being prescribed off-licence, then legislation would prevent an owing from being supplied more than six months after the appropriate date. For guidance go to www.rpsgb.org.uk

Your views

A Society that is embracing change

President Hemant Patel FRPharmS believes the RPSGB is well positioned to take pharmacy forward

It may only be February but the new year seems a long time ago with so much having happened in the first two months of 2007. Clearly this is set to be another year of opportunity and challenge for community pharmacy and the Society will continue to work to support members through this time of change.

Last week a report called Keeping it Personal, written by the Department of Health's national director for primary care Dr David Colin-Thomé, predicted that although the traditional relationship between patients and GPs is unlikely to change over the next 10 years, the services that patients are offered will be fundamentally transformed.

Community pharmacists lining up alongside GPs, nurses and other members of the primary healthcare team are perfectly placed to take on the increasingly innovative clinical roles that will reduce pressure on GPs while cementing the vital role we play in local healthcare. In many parts of Great Britain, pharmacists already deliver enhanced care such as minor ailment schemes, testing and screening services and stop-smoking clinics – all of which take place within the pharmacy itself – and the scene is now set for more exciting advances.

In order to make the most of new opportunities, the profession must learn how to adapt. The Society must also be willing to embrace change and with this in mind, this month saw the first meetings take place of the RPSGB's new pharmacy boards for England, Scotland and Wales. These will help the Society maximise its influence across all three countries and engage more effectively with the devolved health agendas. The boards will enable the Society to implement developments in pharmacy practice with the needs of the individual country's unique social and political circumstances taken into account.

To carry out its work effectively, the Society requires powers that are suited to the needs of a modern day professional and regulatory body. Last month, the long awaited

Pharmacists and Pharmacy Technicians' Order 2007 (aka Section 60 Order) was debated and approved in both the House of Lords and the House of Commons and has now been formally made by the Queen through the Privy Council. This important piece of draft legislation was broadly welcomed across the parties, meaning that pharmacy professional regulation can now be properly overhauled and modernised.

The Section 60 Order represents a triumph for the Society's long-term efforts to influence government policy. The importance of this development, which addresses the modernisation of the Society and the pharmacy profession as well as public protection, cannot be emphasised enough.

In this column I have taken the opportunity to focus on the future but will end by looking back in offering my sincere congratulations to the British Pharmaceutical Students' Association (BPSA) on its 65th anniversary. Founded in 1942, the BPSA is the official student organisation of the Society and is unique as the only national body that represents pharmacy students and pre-registration trainees.

The BPSA does some excellent work in providing education, training and both social and professional opportunities to its members and I wish today's members the very best in their future pharmacy careers.

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Phoenix knights

Paul Smith squares up to wholesale changes as he replaces David Cole at the helm of Phoenix

Max Gosney

On a scale of tough jobs, chief executive of a pharmaceutical wholesaler must rank somewhere near Conservative leader and England football manager. Prestigious posts at proud institutions, but each finding it tough to come to terms with changing times.

"We don't have a god-given right to exist," says Paul Smith, who this month moves from managing director of Rowlands Pharmacy to take the helm from David Cole as chief executive at Phoenix.

At the top of his in-tray will be moves by several drugs suppliers to review the supply of their medicines to pharmacies.

"We are going to have to adjust to what Pfizer and other manufacturers plan to do. It's very difficult to make long-term plans when the market could change dramatically within a year," he says.

Manufacturer deals

- Pfizer – plans to appoint UniChem as sole distributor for its POM medicines from March
- AstraZeneca – launched a review of drugs distribution
- Novartis/Eli Lilly – both considering supply of products

A switch to a system where manufacturers appoint wholesalers on a fee for service basis, as proposed under Pfizer's direct to pharmacy deal, has huge fallout, says Mr Smith.

"At the moment pharmacists are the customer and as such have the power to negotiate the cost. However, under Pfizer's plans suddenly the manufacturers will dictate the terms of business. It follows we will see a reduction in discounts for everybody."

Declining discounts could mean wholesalers cut back on pharmacy services, says Mr Smith. "When wholesalers agree to underwrite a bank loan for pharmacists looking to buy a business it's on the basis that they will be doing around 80 per cent of their orders through us. If that falls to 50 per cent because we don't have the deal to supply a certain manufacturer's products, then is it commercially viable to continue?"

Margins may also be hit by the demand of making more deliveries of fewer drugs, adds Mr Cole, who will continue at Phoenix as deputy chairman. "Wholesalers can adapt to fee for service, but is it sustainable to send out a single packet of drugs to an isolated pharmacy? That will have to cost the NHS more money."

The authorities must act to ensure moves by manufacturers don't result in patients paying more, he adds.

"We cannot stop manufacturers, it's got to be the government. A fee for service model is not how pharmaceutical distribution has been done in the past. What's plan B if this goes ahead?" It appears both Mr Smith and Mr Cole will be searching hard for the alternatives in the coming months.

Mr Cole concludes: "We have reservations about the Pfizer model starting a trend of change. But as an individual company, Phoenix needs to respond to market needs."

Paul Smith on:

The new job: "I've been involved with Phoenix since the company entered the UK and it's a very interesting challenge. It's a highly successful company and I'm looking to maintain that."
Acquisitions: "We will focus on the retail side of the business rather than wholesaling."
Numark: "The group has moved forward in dealing with the needs of members in different parts of the UK, particularly under devolution. I'm pleased with the performance of the own-label brand. I want the group to be indispensible to independents."

David Cole on:

Leaving the job: "It's a combination of personal and business reasons. I've overseen an intense period of large acquisitions and integrating those into the company. I haven't slowed down in 20 years so maybe now is the time to."
His new role: "It's concentrating on strategy and getting more involved at Numark. I'd like to see the membership exceed 2,000."
The high point: "Bringing a substantial number of separate businesses into a single unit."
The low point: "In the early years you never see anything getting better. It's difficult to look beyond short-term problems."

Should POMs go OTC? Join the debate at www.dotpharmacy.com ›

Over to you, Paul: Paul Smith (far right) takes the stand as Phoenix chief executive as David Cole becomes deputy chairman at the healthcare group

Comment from the editor

Viagra on demand will raise consumer perceptions

Viagra on Valentine's Day. From a marketing point of view, it's just brilliant. And it's National Impotence Day to boot.

Following on as it does from last week's debate on supplying the contraceptive pill over the counter, this will certainly raise the perception of what community pharmacy can do in the eyes of the public. Consumers, who are already used to getting Xenical from Boots via the patient group direction route, will now be able to obtain Viagra from Boots pharmacists.

Yes it would be great if all pharmacies could offer this service, but it's got to start somewhere and the knock-on effects will benefit all pharmacies, as patients get used to talking to pharmacists about a topic that has in the past been reserved for their next GP consultation. And with the rollout this year of pharmacists with a special interest and pharmacist independent prescribers, the public face of community pharmacy is unrecognisable from just a decade ago.

The Healthcare Commission, which oversees the PGD process, has stated its intention to make the procedure as easy as possible. This is welcome news but the difficulty lies more in the work that is required to get the PGD ready for presentation to the Commission.

As the NPA argues, the work involved in getting a PGD registered on top of the regulatory burden of running an NHS pharmacy contract does little to level the playing field. And the fact that Boots alone has managed to implement private PGDs must add weight to how difficult the process is.

If the government is serious about developing its self-care agenda then it must cut the regulatory hurdles that pharmacists need to overcome. Scotland has led the way by rolling out an NHS PGD that allows pharmacists to supply the full amount of repeat prescriptions.

Wouldn't it be great if such a scheme was extended across the UK? With the NHS backing the PGD process rather than a private provider, it would be much easier to offer services, such as the one launched by Boots, from all pharmacies. A situation that would give choice to patients, reduce the burden on GPs and make better use of pharmacists' skills.

With the NHS backing PGDs, services like this could be offered from all pharmacies

Your views

Increased knowledge – increased liability?

Colette McCreedy, NPA director of practice, suggests pharmacists need guidance on access to patient records

Last month the NPA released a position statement that made the case for pharmacists to have increased access to clinical information via the electronic NHS care record. We have argued that greater knowledge of patients' conditions and, if appropriate, past medical history, can only enhance the role pharmacists play in ensuring patient safety.

But as with many other areas of practice, greater rights will also bring greater responsibility.

Although it seems rollout of the electronic care record is still some time away and pharmacist access is still a matter of debate, pharmacists are already asking the NPA about the implications of greater access. The NPA has made its position clear; we will be pursuing policies that promote the advancement of pharmacy practice and as an indemnity insurer we will need to underwrite the risk associated.

However, as a defence organisation we will need to assess on an ongoing basis the implications for risk and therefore costs of indemnity cover. As costs increase we would be looking to get them built in to the cost of service model using the so called 'fair funding' model.

So what are the issues? Pharmacists have had access to their own patient medication records for some time, so working with historical patient information is not new to pharmacy. The implications of this information were brought into sharp relief by a recent court case involving a pharmacist who dispensed a prescription accurately and within the therapeutic range but the dose ordered was at variance to that recorded in the PMR.

It was alleged that they did not act upon information contained within the PMR and so the patient came to harm. This is a debatable point. What we will never know of course is, even if the prescription had been compared against the record and if this had triggered a query with the GP, there is no guarantee that the prescription would have been altered.

What is clear is that as the professional role expands there will be a corresponding increase in risk. Pharmacists will be expected to exercise professional discretion by factoring in all available information in the treatment of patients.

In court pharmacists will be judged against what a reasonably competent pharmacist would have done in the same circumstances with the same information.

The NPA is looking at the liability implications of a changing role including increased access to patient information by asking questions such as:

- What should a pharmacist take into account when examining a patient record?
- How does a pharmacist respond to areas where a query may be in order?
- What happens where a dispensing pharmacist and prescriber reach an impasse on what is best for the patient?
- In essence what are the legal implications associated with pharmacist access to patient records?

Pharmacists need guidance here, and help on assessing what is an acceptable risk to avoiding every single issue or interaction being queried. At what point do you override what a doctor says and refuse, for example, to dispense a prescription?

The NPA will be making sure that any potential risks, new or existing, are dealt with in a way that is conducive to a busy pharmacy environment. And we will be seeking to do this before rather than after care record access becomes a reality.

Xrayser

Topical Reflections

OTC Pill – dream on

I can imagine myself selling the Pill over the counter. I'd be taking plenty of time consulting with individual patients, their complete medical record open in front of me, stethoscope at a rakish angle... oh no, wake up – that's the one where I'm a doctor.

It's easy for my imagination to get carried away these days. Hours of CPD feed this new-found confidence in my clinical knowledge, and high profile initiatives and spin doctored messages open doors in my mind to limitless new roles. But the Pill OTC – it ain't going to happen.

If we want to get more involved in contraceptive supply, I suggest we promote the fact that we can make emergency supplies. That's the next best thing and we can do that already. There's no point having an OTC Pill unless all variants are switched at the same time because we'd only have one brand to prescribe and that isn't really prescribing at all. OTC EHC has worked because there was only one switch involved and women will pay for a one-off emergency treatment.

The other reason we don't make many emergency supplies, of course, is that women have to pay for them. Everyone is used to contraception being free at the point of access in this country, just as all other NHS services are generally free. Who's going to pay us to supply the Pill, if not the patients themselves? Exactly.

I have no doubt that I'm clinically competent to supply the Pill, a short training course withstanding perhaps. But the practicalities of making it available to me are mind boggling. Even if all the manufacturers, the government, the public, every interested clinical organisation, the RPSGB and the national media all worked together to make it happen, I doubt that I would have the time. If I had to down tools to have a consultation every time I had a request for the Pill I'd never get out of the consultation room.

It's a good debate to have nonetheless. Please spread the word about how clinically able I am and how willing I am to extend my role. Also reaffirm how well I've handled previous switches and how highly the public value my knowledge and advice. But leave prescribing the Pill to GPs.

A serious switch

The POM to P switch of tranexamic acid for heavy menstrual bleeding, however, is much more likely to happen, as Meda Pharmaceuticals has applied to the MHRA for a P licence (C+D, February 10, p11).

All POM to P switches are good news, but the POM version of this medicine is not exactly a fast mover and this must make it a less than ideal candidate for switching.

I wonder whether:

a) This is not a common problem for women.

b) Few women are aware there is a drug available, or

c) Doctors believe there are better alternatives.

B would be my preferred answer; there must be less benefit to a switch if the answer is a) and virtually none if the answer is c).

There has been an obvious market for previous successful switches, such as chloramphenicol eye drops and ranitidine, which have always flown out of the dispensary. I still welcome the switch even if it has limited sales potential, but if pharmacists and consumer advertising can raise awareness of a useful medicine, that is great news.

C+D

LPC Inbox

Control of entry tops the agenda

The inbox has been dominated by control of entry issues and financial recovery initiatives this month.

Some notifications are simple transfers of ownership following the fall-out from the Boots-Alliance merger; however, there are also a significant number of exempt applications, all trying to get in before any potential revisions or the impact of the Health Bill.

All these applications bring with them a considerable amount of work for an LPC, with site visits, impact assessments, regulation checks, discussion with pharmacy practices in the affected area and preparation of an LPC response.

It is important that this is undertaken in a robust and appropriate manner as, if our contractors should expect anything from us, it is just that.

All these applications bring with them a considerable amount of work for an LPC

One area of increasing activity is the development of primary care premises by companies that also have a subsidiary or associated pharmacy company. Very often, PCTs will see this as a plus as it takes the estate investment risk away from the PCT, which is sometimes only informed once the development is under way, but not always in line with its local delivery plan or pharmaceutical needs assessment. The concern is that we will see much more of these control of entry exemptions to the detriment of our existing resource.

Financial recovery continues to throw a net over much LPC activity, but by working with the PCTs and other stakeholders we can frequently smooth the waters of implementation of cost-reduction initiatives, such as 28-day prescribing, switching and reduced referrals utilising existing elements of the contractual framework including repeat dispensing and MURs.

Written by an LPC officer

NPC Plus in association with C+D

Cardiovascular Risk and Respiratory Disease Workshops

Manchester – Tuesday, 13 March 2007

Leeds – Thursday, 15 March 2007

Warwick – Tuesday, 20 March 2007

Rated 'high quality' and 'very relevant' by pharmacists at 2006 event

The Workshops

Cardiovascular risk

Epidemiology and burden of CVD
What causes variations in the incidence of CVD?
How to communicate risk to patients

Lifestyle interventions

Evidence for various non-drug interventions
How do we implement this in practice?

Lipid-regulating therapies

What does the evidence show?
Choice of statin
Implications of the Heart Protection Study

Hypertension

Evidence around choice of drug therapies
Practical implications of theclinical evidence

Antiplatelet therapy

When should aspirin be given?
What is the role of clopidogrel?
What is the role of other antiplatelets?

Registration: 6.30pm (coffee, light refreshments)
Workshop start: 7.30pm
Workshop finish: 9.30-9.45pm
Buffet supper: 9.30pm

Places limited so book early

Respiratory disease

Epidemiology, burden of illness and natural history of COPD and asthma
Diagnosis issues for COPD and asthma
What does the National Guidance say?

Asthma

Evidence-base around various treatment options with a particular focus on:
Inhaled corticostreroids
Long-acting beta-agonists
Evidence around choice of delivery system?

COPD

Evidence-base around various treatment options with a particular focus on:
Inhaled corticosteroids
Long-acting bronchodilators (tiotropium and beta-agonists)
Smoking cessation

Cost to register £35 +VAT (£41.13) per person.

Telephone Pauline Sanderson on 01732 377269
or send the form below with payment to:
Pharmacy Projects, Pharmacy Group, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Venue selection
❑ MANCHESTER – Tuesday, 13 March 2007, Marriott Worsley Park, Manchester M28 2QT
❑ LEEDS – Thursday, 15 March 2007, Holiday Inn, Garforth, Leeds LS25 1LH
❑ BIRMINGHAM – Tuesday, 20 March 2007, Hilton Hotel, Junction 15 M40, Warwick CV34 6RE

Workshop selection (one only)
❑ CV risk
❑ Respiratory disease

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C+D Clinical

Advising on diabetes

The first of two articles looks at the diagnosis and general care of type 2 diabetes

Key points

- It is important to raise the awareness of the signs and symptoms of type 2 diabetes to aid earlier identification.
- Patients have a huge amount of information to digest because of the multi-factorial nature of the disease and community pharmacists are well placed to support this process.
- The new pharmacy contracts provide ideal platforms for community pharmacists to enhance their support.

Reflect

Do you know how type 2 diabetes is diagnosed? What support do you offer people with this condition? What parameters should be assessed in a diabetes review? What is the significance of HbA1c and microalbuminuria?

Plan

If you feel you could improve the service you give to people with type 2 diabetes, reading this article will update you on the diagnosis, aims of treatment and how the condition should be monitored.

Claire Jones

There are just over one million people in England and Wales with diagnosed diabetes (2 per cent of the population). Of those, about 80 per cent have type 2 diabetes, and it is estimated another million people in England and Wales have undiagnosed type 2 diabetes.

Type 2 diabetes is a progressive condition more commonly diagnosed in the over-40s. With an ageing population and rising obesity, its prevalence is increasing and there is now a significant emphasis on its treatment with national guidance in the National Service Framework for Diabetes[1] and the various publications from Nice.[2]

In addition, diabetes management is a key component of the quality and outcomes framework (QOF) in the GMS contract (see Table 1, overleaf). GP practices are paid for meeting quality indicators in the QOF.

This article and the second, next week, will give an overview of the management of type 2

The College of Pharmacy Practice

This course (module 1396), in association with multiple choice questions being published in C+D March 3, provides one hour's continuing education

CPD This article can help in the following CPD competencies: C1c, C1d, C1l, C3e, G1c,G1o. See www.tinyurl.com/194zu

There are just over one million people in England and Wales with diagnosed diabetes (2 per cent of the population)

diabetes and describe how pharmacists can enhance management as part of the wider primary care team. This article concentrates on managing high blood glucose levels, but type 2 diabetes is a multi-factorial disease and it is essential to treat other risk factors as well, particularly hypertension and high cholesterol.

Who is at risk?

Type 2 diabetes results from reduced insulin production and/or reduced tissue sensitivity to insulin (insulin resistance). Family history, certain ethnicities, and overweight and physical inactivity are risk factors.

Aims of treatment

Treatment goals are to relieve acute symptoms and prevent long-term complications while avoiding hypoglycaemia. The general management should be aggressive to reduce life-threatening microvascular and macrovascular complications.

Microvascular complications, due to small blood vessel damage lead to retinopathy, nephropathy and neuropathy.

Macrovascular complications resulting from large artery damage lead to coronary heart disease (CHD), stroke and peripheral vascular disease (which can result in amputation). Mortality rates from CHD are up to five times higher for people with diabetes, while the risk of stroke is up to three times higher.

How is it diagnosed?

The four common symptoms of diabetes are: excess thirst, passing large amounts of urine, tiredness and weight loss. In type 2 diabetes some people develop symptoms so gradually they become used to them and the diagnosis may not become apparent for some time. It is important to raise awareness of these signs and symptoms, and health promotion campaigns are an ideal avenue for this.

While screening is not recommended for all, targeting certain groups at higher risk of developing the disease, such as those with multiple risk factors (obesity, South Asian descent, family history, etc) is worthwhile.[3]

Venous plasma glucose tests are among the tests used to confirm type 2 diabetes, and the WHO has set diagnostic thresholds:

- Random venous plasma glucose test – higher than 11.1mmol/l.
- Fasting test (ie after an overnight fast) – higher than 7mmol/l.

Diabetes UK recommends the fasting level as a diagnostic test as it is more sensitive and specific than the random plasma glucose test. It is also recommended that diagnosis in an asymptomatic person should never be based on a single abnormal plasma glucose level; at least one additional abnormal level is required.

Monitoring

Guidelines recommend that treatment should aim to achieve a blood level of glycated haemoglobin (HbA1c) of between 6.5 per cent and 7.5 per cent, depending on the risk of complications. HbA1c measurements reflect the average blood glucose level over the preceding three months and hence indicate how well the diabetes is controlled. HbA1c levels should be measured at two to six month intervals depending on the stability of control.

Table 1: Examples of diabetes mellitus (DM) quality indicators in the GMS contract

DM 2:	The percentage of patients with diabetes whose notes record BMI in the previous 15 months.
DM 20 *(and DM 7)*:	The percentage of patients with diabetes in whom the last HbA1c is 7.5 *(or 10)* or less (or equivalent test/reference range depending on local laboratory) in the last 15 months.
DM 12:	The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.
DM 15:	The percentage of patients with diabetes with proteinuria or micro-albuminuria who are treated with ACE inhibitors (or angiotensin II receptor antagonists).
DM 17:	The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is five or less.

Table 2: Key points covered with a newly diagnosed patient

- Explain about the key long-term complications of diabetes and the importance of good metabolic control, so stress importance of compliance with medication.
- The major long-term complications are microvascular (retinopathy, nephropathy, neuropathy) and macrovascular (peripheral vascular disease, CHD and stroke).
- Stress the importance of lifestyle modifications:
  - Provide dietary advice (eg limit sucrose intake, eat more high fibre foods, reduce total fat intake, use salt only in moderation, decrease alcohol intake).
  - Calculate BMI and agree target weight. Explain that weight loss lowers blood glucose, lipid levels and blood pressure.
  - Discuss smoking cessation if appropriate (smoking doubles cardiovascular mortality in diabetes).
  - Discuss an increase in physical activity if appropriate.
- Explain the signs of hypoglycaemia and what to do. Symptoms include trembling, sweating, anxiety, blurred vision, tingling lips, paleness, mood change, vagueness or confusion. Missing meals, not eating regularly and drinking too much alcohol can increase the risks. Remember that the warning symptoms of a hypoglycaemic attack may be masked during concomitant treatment with a beta-blocker.
- Counsel patient as to the increased susceptibility to certain infections.
- Explain the importance of regular foot care.
- Explain the importance of annual eye examinations.
- Explain the clinical manifestations of neuropathy, eg loss of peripheral sensation, postural hypotension and impotence.
- Discuss the possibility of patient self-monitoring (see next week).

Table 3: How the pharmacy contract can support people with type 2 diabetes

Essential services

- Use repeat dispensing services to pick up any problems that patients may be experiencing with their therapy and to ensure that they are receiving ongoing support and monitoring.
- Better inform patients through signposting services and health promotion campaigns.

Advanced services

- Target diabetic patients for MURs to improve the use and understanding of their medication.

Enhanced services

- Improve management of medicines through medicines management services.
- Promote multidisciplinary care of people with diabetes through supplementary and independent prescribing services.
- Promote healthier lifestyles through, for example, stop smoking services.

Lifestyle interventions

Lifestyle interventions are key in both prevention and treatment. Studies have shown that lifestyle interventions can prevent type 2 diabetes. In 2001 the Finnish Diabetes Prevention Study showed that intensive lifestyle intervention (individualised counselling aimed at achieving defined weight-loss, exercise and dietary goals) over four years in people with impaired glucose tolerance halved their risk of type 2 diabetes.

Modifying the diet, increasing physical activity and stopping smoking are all key interventions to encourage. The diet recommended for people with type 2 diabetes is the same healthy diet that is recommended for everyone. This is likely to mean reducing fat (particularly saturated fat) and salt intake, while increasing fruit, vegetables, fish and fibre-rich starchy foods such as rice.

How to improve patient care

Pharmacists can improve the care of type 2 diabetes in many ways, not least by making patients aware of the signs and symptoms and ensuring they know what to expect from their medication (as described next week).

Table 2 describes all the information that will be discussed by the GP and diabetes nurse with a newly diagnosed patient. There is a huge amount for a patient to take in and retain, and community pharmacists have a key role in ensuring that patients understand this information and know where to go for help.

Excellent patient leaflets are available from Clinical Knowledge Summaries[4] (PRODIGY) and Diabetes UK.[5]

Because of the progressive nature of the disease, ongoing support and monitoring is essential and again pharmacists have a key role, for example, in stressing the importance of regular review. Depending on the frequency of review, it will include:

- Reviewing the overall management of lifestyle interventions (eg diet) and drug therapy (eg compliance and side effects).
- Testing urine for protein. The urine of people with type 2 diabetes should be tested regularly (at least annually) for proteinuria (over 300mg albumin/day) and, if this is negative, for microalbuminuria (over 30mg albumin/day). People with diabetes and microalbuminuria have about two to three times the coronary morbidity and mortality of people with normal levels of albumin and a similar duration of diabetes. Patients with type 2 diabetes who have protein in their urine will be started on an ACE inhibitor (or angiotensin II receptor antagonist) (see Table 1).
- Measuring HbA1c level (Nice recommends every two to six months).
- Discussing the results of any self-monitoring.
- Weighing the patient.
- Checking blood pressure.
- Measuring serum creatinine and cholesterol.
- Retinal examination. Up to 40 per cent of people have some retinopathy when type 2 diabetes is first diagnosed.
- Foot examination: 15 per cent of people with diabetes develop foot ulcers associated with nerve damage (neuropathy), reduced blood supply (ischaemia) or both.

There are many ways pharmacists can raise awareness and support people with type 2 diabetes within the structure of the new pharmacy contracts. Table 3 describes how this can happen in England and Wales.

Part 2 next week will cover the drugs used in treatment of type 2 diabetes.

For further reading and references go to www.dotpharmacy.com/diabetes

Claire Jones is now practising as a community pharmacist and carrying out consultancy work after four years as assistant head of NHS service development at the National Pharmacy Association. She previously worked as a pharmaceutical adviser and National Prescribing Centre trainer.

Continuing Professional Development CPD

Act

- Visit other websites as well as the ones mentioned. eGuidelines (www.eguidelines.co.uk) offers many articles on the subject. A recent review site is www.medscape.com/viewarticle/546710. Bandolier is also useful – www.jr2.ox.ac.uk/bandolier/band128/b128-4.html#Heading5
- In the next 12 weeks record all your regular patients who are prescribed oral hypoglycaemics. Note any characteristics that may be linked to their condition, using the 'who is at risk' paragraph as a starting point.
- List the lifestyle interventions and what advice you would give.
- Using the above list can you identify any other patients who might be at risk of type 2 diabetes?
- Now record some interventions with known diabetics. Also consider discussing lifestyle changes with people who are undiagnosed but who could have the disease (overweight, smokers who do not exercise) and whether they should consult their GP.
- Make sure you know and can apply the points made in Figure 2 (points covered with a newly diagnosed patient).
- Review the meaning of the results of self-tests/self-monitoring.
- Have you thought about setting up a pharmacy-led diabetes clinic? Consider what it would entail. Clearly there are limitations but it might be possible to involve a practice nurse. If you think it is feasible, speak to your local GPs.

Evaluate

- In three months' time, look back on your records of interventions. Talk to those patients to whom you spoke. Did they learn anything from your advice? Have they changed anything (lifestyle, smoking, diet etc)?
- Having read the article and followed some of the suggested actions, do you feel better equipped to advise people with newly diagnosed type 2 diabetes? Now check your current knowledge. Identify a patient who has been diagnosed as hyperglycaemic and discuss their treatment with them, using the article as a background.

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 3 issue, which will cover this week's CPP-accredited module, together with those in the February 3 and 24 issues.

These will cover:

- Treating cystitis and PMT (1395)
- Diabetes part 1 (1396)
- Diabetes part 2 (1397)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

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C+D GENUS PHARMACEUTICALS

A Practical Approach...

David Spencer, the pharmacist in the Update Pharmacy, is in the dispensary when he hears a commotion in the shop and rushes out to see what has happened. A young woman has been brought in who is in a state of collapse, breathing with great difficulty and with a swollen face and lips.

A man who brought the girl in says: "I think she needs help urgently. I found her with her friend further down the street and I thought that this would be the best place to bring her."

The friend manages to tell David that her friend has a nut allergy. They were having lunch in a local café and she thinks the girl must have eaten something contaminated with nuts. David asks if her friend carries any medication for emergencies like this. She says she doesn't know, looks in the girl's handbag and says she can't find anything.

David is pretty sure that the girl is suffering anaphylactic shock and needs an intramuscular injection of adrenaline 0.3mg; he knows he has one in stock. But in the seconds before he acts the following thoughts flash through his mind:

"She's really in a bad way, but I've never used one of these adrenaline injector pens before. What if I don't do it properly and it doesn't work or I actually make her worse? Am I likely to be sued or prosecuted or struck off if things go wrong? Is supplying or administering the drug like this illegal? Should I just call an ambulance and give basic first aid in the meantime?

Questions

1. What are the answers to David's questions?
2. What should David do? Answers →

CPD This article can help in the following CPD competencies: C1a, G1g, G1h. See www.tinyurl.com/194zu

Antibiotic resistance 'striking'

A "striking" demonstration of the association between antibiotic use and antibiotic resistance has been shown by European researchers.

Their results highlight the vital importance of restricting the use of antibiotic drugs.

In a randomised controlled trial, 224 healthy volunteers were treated with azithromycin, clarithromycin or placebo.

Pharyngeal swabs showed significant increases in the numbers of resistant bacteria after treatment, which hit a peak at day eight in participants given clarithromycin, with an average increase of 50 per cent.

By day four the proportion of macrolide-resistant organisms in the azithromycin group had increased by 53.4 per cent.

Overall, azithromycin treatment was associated with the most resistance, with the biggest difference between the two groups at day 28.

Effects were long-lasting, with resistant bacteria still present at the six-month end point of the trial.

Study leader, Professor Herman Goossens, professor of medical microbiology at University

Hospital Antwerp, said he had not expected such dramatic results or such a long-lasting effect. "By six months the levels of resistant bacteria hadn't even reached baseline.

"Physicians don't see the immediate effect but with this study we see the impact – we have a massive increase in the proportion of resistant bacteria."

For more information:
Lancet 2007; 369: 482–90

Pandemic will need arsenal of antivirals

Stockpiling Tamiflu alone is not sufficient to protect the population in the event of a flu pandemic, public health experts have warned.

Writing in the BMJ, a team from Greece and the UK said it was impossible to predict what drugs would be effective against a new pandemic strain and choosing only to stockpile the neuraminidase inhibitors could be a "costly" mistake.

The M2 ion channel inhibitors, amantadine and rimantadine, have largely been left out of pandemic planning because they are associated with unacceptable side effects and a rapid emergence of resistance.

However, Sotirios Tsiodras and colleagues argue that because of the unpredictability of antiviral susceptibility for new strains and because the emergence of resistance may be reduced when the drugs are used in combination, their use should be reconsidered.

"Ion channel inhibitors could yet have an important role in our armoury against a future flu pandemic," they concluded.

For more information:
BMJ 2007: 334; 293-94

A Practical Approach... this week's answers

1a)There is no legal obligation in UK law to help others in danger or distress, but most people would consider it their moral duty to do their best. The Royal Pharmaceutical Society's Code of Ethics (Part 3: Service specifications; 15. Emergencies) requires pharmacists to assist persons in need of emergency first aid within their competence, so David could be guilty of professional misconduct if he refused to offer any help.

b) Case law has established that a person, even a health professional, providing voluntary first aid in an emergency is not required to provide the same standard of care as would be expected under normal circumstances. So David is unlikely to be sanctioned in any way if his well-meant attempts at help should fail.

c) There is an exemption to the legal restrictions controlling supply and administration of medicines, allowing adrenaline 1 in 1,000 to be administered for the purposes of saving life in an emergency. The injection can be given by anyone, with the consent of the person receiving it, which may have to be assumed in this case.

d) Calling an ambulance and waiting is a poor option in this case as David has the means to provide immediate life-saving treatment. If he tried to 'cover his back' in this way he could face criticism and perhaps disciplinary action by the Society, as it would be in contravention of the Code of Ethics requirement for pharmacists to make the interests of patients their prime concern (Part 2. Standards of professional performance; A. Personal responsibilities).

2. David should administer the injection, which is what he did.

Elderly COPD patients struggle with inhalers

Many elderly patients with COPD are unhappy with their prescribed inhaler and those who are satisfied are often unsure if they are getting any clinical benefit, UK researchers have reported.

A study of 53 people with COPD found 46 per cent of patients using a metered dose inhaler and 17 per cent using a dry powder inhaler rated their device difficult to use.

All patients in the study used a metered dose inhaler and when asked, 31 felt they were able to perceive benefit after use.

However, only four of the 12 dry powder inhaler users reported they could feel the benefit of using the inhaler.

Half of those on dry powder inhalers were 'unsure' as to whether they received any clinical benefit despite reporting them easy to use.

Further analysis showed most patients were unable to generate sufficient inspiratory flow to use the higher resistance dry powder inhalers and those that could tended to have milder disease.

The team concluded future development of new devices including cheap, portable, user-friendly nebulisers would be helpful.

For more information:
Age and Ageing published online January 31, 2007

Upcoming Nice decisions announced

Nice has been asked to evaluate adalimumab for moderate to severely active Crohn's disease, certolizumab pegol for rheumatoid arthritis, infliximab for ulcerative colitis, and rimonabant for the treatment of obese and overweight patients, says the Department of Health. More information is available at www.nice.org.uk

In brief

Patients with long-term treatment-resistant chronic cough benefit substantially from slow-release morphine, suggests a study in the American Journal of Respiratory and Critical Care Medicine. Researchers found the morphine reduced cough score levels by 40 per cent.

Orlistat has been approved by the US Food and Drug Administration as an over the counter weight loss pill for overweight adults recommended for use alongside a reduced calorie diet and exercise programme.

The rising incidence of influenza has triggered the use of antiviral drugs under Nice guidelines, the DH director of immunisation policy, monitoring and surveillance has announced in a letter to health professionals. Much of the rise is attributable to influenza type A (H3).

The sugar coating of Atarax hydrazine hydrochloride tablets has been replaced by a film coating, supplier Alliance Pharma has announced. Normal supplies of the 25mg tablets have been resumed, and the 10mg tablets are expected within a few weeks.

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C+D &

SMA Nutrition

TUTORIAL 40

Proteins in infant

OBJECTIVES

- To understand the nutritional role of infant formulae in feeding babies
- To learn about the protein composition of breast milk and infant formulae based on cows' milk
- To know how developments in dairy technology are leading to changes in the protein composition of infant formulae

While breast milk is the ideal food for babies, a substantial number of mothers will have switched to infant formulae by the time their child is six months old[1]. Developments in dairy technology mean that the protein composition of formula feeds is coming closer to that of breast milk with some potential benefits for infants

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This tutorial can help with the following CPD competencies:
G1a, G1c, G1q, G2o, C1f, C3h

While breast milk is best for babies, infant formulae play a vital nutritional role where mothers are either unable or do not wish to breastfeed their child. Technological advances mean a new generation of infant formulae are on the horizon, containing a balance of proteins closer to those in breast milk

Breast milk provides all an infant needs for healthy growth and development. The essential building blocks of life, from proteins, carbohydrates and fats, through to immunoglobulins and prebiotics, are present in breast milk at optimum proportions.

As breast milk is the ideal food for babies, it's not surprising that the Government recommends infants are solely breastfed for the first six months of life. However, in the UK just 69 per cent of infants are fed this way at birth, with the figure dropping to 42 per cent by six weeks of age, and 21 per cent when the infant is six months old.[2] Consequently, in the UK, most babies will receive an infant formula during their first year, when it provides an important source of nutrition.

Infant formulae have been developed with the goal of being as close as possible in composition and physiological benefits to breast milk[3]. For this reason their composition is based essentially on that of human milk. As such, the focus over the past decade has been the introduction of long-chain polyunsaturated fatty acids, nucleotides and prebiotics which confer potential health benefits on infants.

However, the fundamental elements of formulae, such as proteins, have largely been overshadowed. Now, due to developments in dairy technology, a major advance in the protein composition of infant formula has taken place, to bring the composition closer to that of breast milk.

The outcome will be a new generation of baby milks that can deliver further benefits to babies, such as increased essential amino acid levels, reduced total protein content and improved gastric tolerance[3,4,5].

Protein content

Protein is a very important nutrient for the growth and development of infants. Both breast milk and infant formulae based on cows' milk contain two main types of milk protein: whey and casein. Whey proteins are soluble, easier for infants to digest and have lower amounts of potassium and sodium. Casein types are less soluble in the acidic environment of the stomach and have longer gastric emptying times[6,7,8].

Where breast milk and cows' milk formulae differ, however, is in the proportion and composition of milk proteins they contain. Although the levels of protein can fluctuate in breast milk, it is generally accepted that mature breast milk contains 60 per cent whey proteins and 40 per cent casein[9]. While some formulae contain the same protein proportions as breast milk, others contain 20 per cent whey and 80 per cent casein. These latter formulae are called casein-based formulae.

Parents often switch to a casein-based formula if babies still seem to be hungry after a whey-based formula since gastric emptying is slower with a casein based formula[6,7,8]. This may help delay weaning until the recommended time. For example, the Government's Infant Feeding Survey of 2000 found 64 per cent of bottle-feeding mothers gave their children a whey-based formula at 4-10 weeks, dropping to 41 per cent at 4-5 months, and 20 per cent by 8-9 months[2].

The composition of the proteins also differs. The major whey protein in human milk is alpha-lactalbumin (which provides a good source of essential amino acids).[3] Alpha-lactalbumin is only present in smaller amounts in cows' milk (and formulae based on cows' milk).The correct levels of amino acids are important for optimal protein synthesis within the body. The lack of just one essential amino acid can result in impaired infant growth and development[9].

In contrast, the main whey protein in cows' milk (and formulae based on cows' milk) is beta-lactoglobulin. This protein is usually absent in breast milk[3].

Infant formulae have higher protein levels than breastmilk (15g/l, compared with 9-11g/l in breast milk). This ensures that adequate amounts of essential amino acids are provided to meet the growth needs of the infant. The drawback is that the infant has an increased renal solute load (the amount of water needed to support urinary excretion of metabolites) with formulae milks compared with breast milk[9].

Figure 1

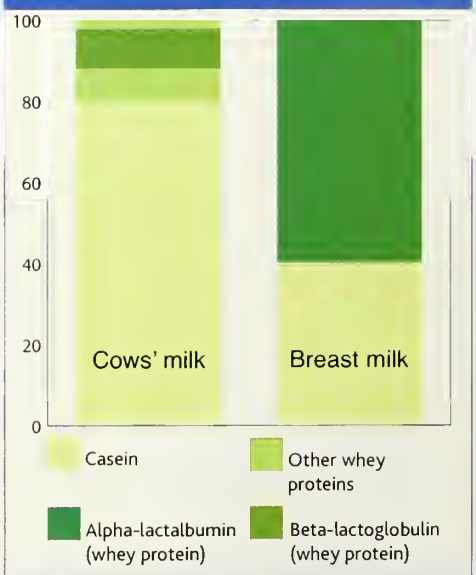

Figure 1: Typical levels of whey proteins (alpha-lactalbumin, beta-lactoglobulin, and others) and casein proteins in cows' milk and human milk[9]. Note that the ratio of whey-to-casein proteins in breast milk is not fixed – it varies from a ratio of about 80 whey: 20 casein in early lactation, to a ratio of about 60:40 (shown here) in mature milk, and changes again to about 50:50 with prolonged feeding

formulae

Figure 2

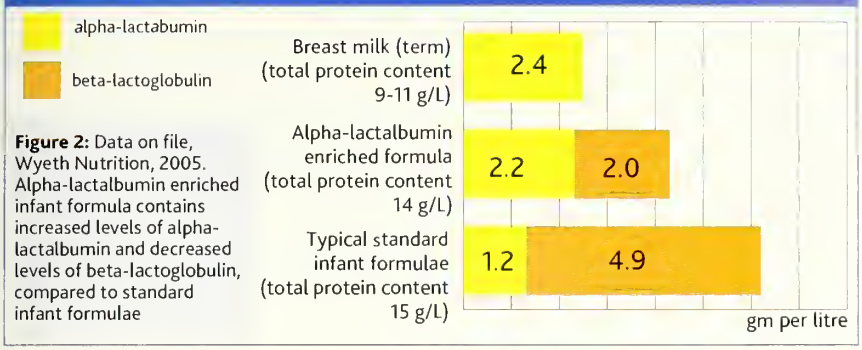

Figure 2: Data on file, Wyeth Nutrition, 2005. Alpha-lactalbumin enriched infant formula contains increased levels of alpha-lactalbumin and decreased levels of beta-lactoglobulin, compared to standard infant formulae

The role of alpha-lactalbumin

Alpha-lactalbumin is a good source of essential amino acids, in particular, tryptophan and cysteine[4,9]. Levels of these amino acids in cows' milk are around half that in human milk when expressed as a proportion of total protein[10].

Tryptophan is a precursor of the neurotransmitter, serotonin, which is thought to play a role in the development of the regulation of food intake, satiation and babies' sleep/wake cycle[10,11,12]. Increasing the tryptophan levels in formulae can reduce the time it takes for babies to fall asleep after feeding[11]. Cysteine is part of the tripeptide glutathione[10]. It is also a precursor of the amino acid taurine, which may play a role in brain development.

The role of beta-lactoglobulin

Beta-lactoglobulin is the main whey protein in cows' milk, and is the main protein in current whey-dominant formulae. However, it is not normally present in breast milk. It has been suggested that it may be a particularly antigenic protein, activating gastrointestinal cells, and is one of the proteins implicated in cows' milk allergy[13].

Protein composition

It is clear that increasing levels of alpha-lactalbumin would bring infant formulae closer to the protein composition of breast milk. Until recently this has not been possible. Recent advances in dairy technology now allow isolation of higher concentrations of alpha-lactalbumin from whey fractions. However, this is only part of the solution; to approach the protein composition of breast milk there also needs to be a corresponding reduction in beta-lactoglobulin content.

The resulting formula could not only increase the levels of essential amino acids delivered to infants but would allow a small reduction in the overall protein included in the formulae. This, in turn would reduce the child's renal solute load.

Data are available to support these hypotheses[3]. Research on an alpha-lactalbumin enriched formula found that only infants fed with this formula had tryptophan levels as high as those of breastfed infants[3]. This formulation resulted in improved gastrointestinal tolerance[5].

To produce an infant formula with alpha-lactalbumin protein levels that are suitable to meet an infant's particular nutritional use, there must be a demonstration of its safety and suitability by appropriate studies.

The real question is the impact alpha-lactalbumin enrichment has on a formula's ability to deliver adequate protein levels and infant growth. A 12-week multi-centre, randomised controlled trial compared such a formula with a whey-dominant control[3]. The ratio of whey:casein remained unchanged, however, the dominant whey protein in the experimental formula was alpha-lactalbumin (2.2 g/l similar to the 2.4g/l seen in breast milk) and beta-lactoglobulin in the control.

While the alpha-lactalbumin enriched formula supported growth as much as the control formula, there was one crucial difference. Infants given the experimental formulation maintained plasma essential amino acid levels despite a reduced amount of protein consumption.

In summary

The new generation infant formulae that contain higher levels of alpha-lactalbumin appear to provide additional benefits to infants. Not only can these formulae support infant growth in the same way as existing products, but they offer an improved amino acid profile with a lower protein concentration.

This translates into less impact on the infant renal system and fewer gastrointestinal problems. The objective of an infant formula that accurately reflects human breast milk is taking a step closer to reality.

References available at www.dotpharmacy.com/SMSrefs.html.

Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our Telephone Marking Service on **08705 800 287** for an immediate result. You will be asked for the Tutorial Number. This tutorial is No 40. Just listen to the instructions and press buttons 1 or 0 to indicate your answers. "1" indicates true; "0" indicates false. Please note that calls are charged only at standard national rates.

This module will also appear on the C+D website, www.dotpharmacy.com, under 'Education' until March 19, 2007.

If you pass this module, and want the appropriate certificate for this College of Pharmacy Practice accredited tutorial, complete the form below and send the original (or a photocopy) to: Pharmacy Projects, CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW before March 19, 2007. Please enter your name, pharmacy, address, and phone number below:

Name:

Address:

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1. Despite recommendations that infants are breastfed for the first six months of life, only 42 per cent of infants actually are
❑ True ❑ False

2. Mature breast milk contains 40 per cent whey proteins and 60 per cent casein
❑ True ❑ False

3. Tryptophan is a precusor of serotonin
❑ True ❑ False

4. The major whey protein in breast milk is alpha-lactalbumin
❑ True ❑ False

5. Beta-lactoglobulin , the main protein in whey-dominant infant formulae, is not normally present in breast milk
❑ True ❑ False

6. To bring the composition of existing infant formulae closer to that of breast milk requires an increase in alpha-lactalbumin and a reduction in beta-lactoglobulin
❑ True ❑ False

7. Beta-lactoglobulin may be implicated in cows' milk allergy
❑ True ❑ False

8. Research suggests that an alpha-lactalbumin enriched infant formula causes fewer GI disturbances than standard formulae
❑ True ❑ False

9. The higher protein levels in formula feeds (compared to breast milk) increase the renal solute load on infants
❑ True ❑ False

10. New dairy technology means new infant formulae can deliver increased essential amino acid levels and lower total protein content
❑ True ❑ False

Pharmacy Champions

Pharmacists leading the way

Pharmacy Champions

Name
Ravi Mohan

Pharmacy
Weldricks Pharmacy, Sheffield

What has he done?
Runs a number of services for students at Sheffield University

What have you set up?
The pharmacy is attached to the University Health Service (UHS) in Sheffield and was newly built about two years ago with a consultation room. Around 20,000 students are registered with UHS.

One area that is high on the agenda for the student population is sexual health. I provide EHC under a PGD for girls aged 15 to 17 and to help stop the spread of STIs we sell condoms at a greatly reduced price.

I also provide a minor ailments scheme with the GPs, which allows us to deal with things such as colds, headaches, thrush and conjunctivitis, while they spend their time on more serious conditions. The patients like it because they don't need an appointment and their ailments can be dealt with quickly.

One of my dispensing technicians has been trained to be a one-to-one stop smoking advisor since a large number of the students want to give up. We also offer H pylori breath tests for patients referred by their GPs. If the results come back positive, I can treat them with triple therapy under a PGD.

MURs have been difficult to carry out on students as they do not usually take a large amount of medication. They're also quite well informed as they have easy access to the internet. The UHS doctors are also good at giving advice on medicines use, making MUR patients difficult to identify.

Were there any difficulties?
Mainly duplication of some services with the GPs and waiting for training from the PCT for accreditation. After discussion, it was apparent that even if some services were provided by both of us, we could work side by side and there was enough work for both teams.

How have the patients and GPs reacted?
I've always had close links with the GPs and tried to tailor the services to our unique customer base. They like working together on things. Providing the services in a relaxed, non-judgmental way encourages more students to use them.

Any advice for others?
Find out what services your locality needs and which are available to provide. This can only be done by forging better relationships with your local healthcare team. Most of all, you have to go out and get the work. Be proactive – very little will just fall into your lap.

Why do you think you've been successful?
I get fantastic support from Weldricks and I have a great team working for me who can run the rest of the business well, in addition to a regular locum who is accredited to provide many of the services and frees up a lot of my time.

I also have a good relationship with the UHS team. My philosophy is that I would rather work in harmony than in competition with them. After all, we all want the same outcome – patient care.

Has offering the service improved your job satisfaction?
The type of patients I see are radically different from those in your average pharmacy and they bring different challenges. I now spend much more time answering questions, counselling and liaising closely with UHS staff. I therefore feel I'm making a difference and my opinion is worthy. I like the fact that people know me by my first name.

Nominate your Pharmacy Champion:
Telephone 01732 377688
or email chemdrug@cmpmedica.com

Sure undergoes image makeover

Deodorant brand Sure for Women is being relaunched with new variants and new pack designs across the board. Products in the Crystal subrange are being reformulated.

Biorhythm is new to the core range while Clear Pure joins the Crystal line-up. Clear Aqua is newly available in a stick applicator.

Supporting the new look, Unilever is spending £9 million on marketing activity, taking in TV and print advertising, sampling, direct marketing and PR. The relaunch positions Sure for Women as offering "incredible protection that works in sync with you", says Unilever.

Price: Biorhythm roll-on £1.59, aerosols £2.09/150ml, £2.89/250ml; Clear Pure aerosol £2.09/150ml, £2.89/250ml; Clear Aqua stick £2.09/40ml

Product info:
Unilever
Tel: 020 8439 6100

Good riddance to head lice

Riddance is a new head lice treatment available from EMT Healthcare. The product, based on neem seed kernel extract, is applied like a regular shampoo with combing recommended once a week to remove egg cases.

Riddance, developed in a research programme with the London School of Hygiene and Tropical Medicine, is described as "totally effective against headlice – even the super bugs".

Supporting the launch, PR activity is targeting TV shows and other media channels.

Price: £6.99/100ml
Pip code: 325-4588

Product info:
EMT Healthcare
Tel: 0115 849 7700
www.neemco.co.uk

Sally Hansen for lips and hands

Sally Hansen has launched two premium hand treatments. The Hand Resurfacer contains micro-exfoliants to smooth the skin while the Anti-wrinkle extra firming hand crème lifts and hydrates the skin.

Also new is a lipcare range. The Lip Exfoliator and Moisturiser is a two-sided lipstick that exfoliates on one side and replenishes moisture on the other. A 24 Hour Lip Treatment for dry and cracked lips containing vitamins A, C and E can be worn alone or under lipstick and the Thin Lip Collagen Boost is said to increase the fullness and volume of lips while reducing lines. A medicated Chapped Lip Repair product and an Invisible Lip Liner complete the line-up.

Product info:
Lornamead Network
Tel: 01276 674000
www.sallyhansen.co.uk

Price: from £5.95 to £6.95

Products in brief

Summer looks beautiful

Superdrug has unveiled its summer line-up and says it has spent £20 million investing in new ranges.

The Solait sun protection range boasts 75 lines. The company has designated May 2007 SAFE month – Skin Awareness For Everyone – with fundraising and educational activities planned.

Other launches focus on the beauty sector and include collaborations with fashionable brands including MeMeMe, Playboy and Miss Nail Bar.
Superdrug
Tel: 020 8684 7000

Licence for the devil

Devil's claw has become the first herbal medicine for oral use to be registered under new regulations. Under the brand name FlexiHerb, MH Pharma gained the licence for the relief of backache, rheumatic or muscular pain and general aches and pains in the muscles and joints. New packs carrying the indication will appear on shelf from June.
MedicHerb
Tel: 01628 400608

NHS signs up Mumtaz

Mumtaz has become the exclusive supplier of halal babyfood to the UK's NHS hospitals. Since its launch last summer, the range has received professional and commercial endorsement. The company plans to expand the range over the coming months.
Mumtaz
Tel: 0870 77 786786.

Oats get the votes

Aveeno Cream has been hailed the patients' favourite emollient for the 10th consecutive year in the North Tees & Hartlepool NHS Trust emollient assessments.

Testers rated nine moisturisers and declared Aveeno the most popular in terms of suitability for their skin's dryness and lifestyle.

Aveeno Cream contains finely ground oatmeal. Other studies have shown it to be well liked for being light and non-greasy, and for improving the feel of dry skin, says J&J.
Johnson & Johnson
Tel: 01628 822222

Going all misty eyed with Savant

Clarymist is set to benefit from a distribution, PR and advertising push this year, reports UK distributor Savant. Various media channels including television, newspapers and glossy magazine will be used in the £250,000 promotional campaign.

The product, launched last year, treats dry eyes, a condition believed to affect up to four million people in the UK. It contains soya lecithin, a soya extract commonly used as a food ingredient. Applied to closed eyes, it is said to be the only eye spray on the market.

The product is suitable for contact lens wearers and can be used up to three years after opening.

In a clinical trial of 382 subjects, 89 per cent reported a reduction in dry eye symptoms as a result of using Clarymist. The product stabilises the lipid layer, sealing in the tears and alleviating burning, scratching and grittiness, says Savant. The patient should blink after applying the product, which takes a minute or two to take effect.

Product info:
Savant Distribution
Tel: 0845 060 6070
www.savant-health.com

Flix sticks enter pharmacy

Flix interdental sticks are making their retail debut. The plastic sticks can be used for flossing, removing plaque and massaging gum tissue, says Mirage.

Three variants are available: orange flavoured, mint flavoured and a charity product. From each sale of the latter, 10p will be donated to the Breast Cancer Haven charity.

Supporting the launch, marketing activity begins in April and will continue for 14 months, reaching an estimated 10 million UK consumers. The Are you ready to be Flixed? campaign was first introduced to the dental profession at the end of last year to garner awareness and recommendation.

Product info:
Mirage Dental Products
Tel: 0845 130 5440
www.flixsticks.com

Price: £3.99/40
Pip codes: Florida burst 325-7839; mint sensation 325-7797; charity 325-7821

Johnson's reasons to smile

Johnson's has extended its beauty offering with the launch of a hand cream and three lipcare products.

The lip balms contain vitamin E and UV filters and can be used on a daily basis to moisturise and protect the lips, says Johnson's.

Johnson's 24 Hour Moisture hand cream is said to keep hands hydrated even through hand washing. It reduces skin tightness, improves skin feel and appearance, says the company. Supplied in a slim tube, it is designed to fit easily into a handbag.

Product info:
Johnson & Johnson
Tel: 01628 822222

Price: Lipcare Classic £1.59, 324-0843; Pearly £1.99, 324-0850; Mooncare £2.99, 324-0868; hand cream £1.99/50ml, 324-4373

Galpharm has a sight for sore mouths

A mouth ulcer treatment has been launched by Galpharm.

Applied with cotton buds, Mouth Ulcer is said to speed up the healing process, giving almost instant relief. The affected area is cauterised and only one treatment is necessary, says Galpharm.

Mouth Ulcer claims to be the fastest acting product of its kind. It is supplied in shelf-ready packaging. Training materials are available.

Price: £9.99
Pack size: 3 x 0.2ml
Pip code: 326-0452

Product info:
Galpharm International
Tel: 01226 779911

Hirudoid's one of a kind

Hirudoid from Genus Pharmaceuticals is the subject of a trade advertising campaign targeting pharmacists and practice nurses.

Available in cream and gel formats, the product is indicated for the relief of bruises, varicose veins, sprains and soft tissue injuries. Since the withdrawal of Lasonil, it is now the only heparinoid-based product for such uses, says Genus. It is available on prescription or OTC.

Product info:
Genus Pharmaceuticals
Tel: 01635 568400

Products in brief

Mates shows its stamina

A new condom is now available from Mates. The Endurance is said to aid longer lasting sexual activity. It features a special lubricant to help control climax, says Mates.
Price: £7.42/12, Mates Healthcare
Tel: 01564 711807.

Discontinuation

Forceval Protein Powders will be discontinued once stocks are exhausted. For more information: Alliance Pharmaceuticals
Tel: 01249 466966.

Products advertised on TV next week

clearblue

Abidec children's vitamins: five, Sat
Astral: five, GMTV, Sat
Buscopan: C4, five, GMTV, Sat
Buttercup Cough Syrup: C4, GMTV
Calpol: All areas
Canesten Oral Duo: All areas
Clearblue: All areas
Covonia: five, GMTV, Sat
Cura-Heat Irritable Bowel Syndrome: C4, GMTV, Sat
Cura-Heat Period Pain: C4, GMTV, Sat
DenTek: GMTV
DulcoEase: C4, five, GMTV, Sat
Lanacane: All areas
Lyclear Spray Away: GMTV, Sat
Milton: All areas except five
Seven Seas Cod Liver Oil: GTV, GMTV, Sat
PharmaSite for next week: Anadin Ultra – Pharmacy channel: Vega Nutritionals, Day & Night Nurse capsules, Aveeno

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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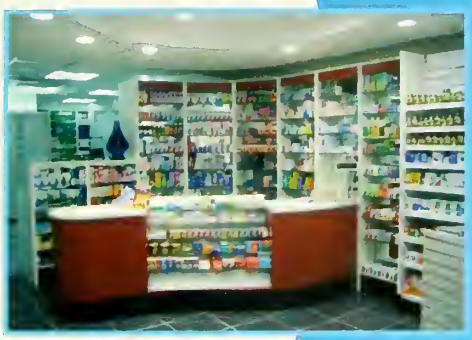

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Oldham teenagers invited to 'Kiss My Butt'

More than 2,800 teenage smokers saw 'Kiss My Butt', a play specially commissioned as part of the Smoke Free Oldham Campaign. Young actors from Oldham Theatre workshop toured local schools in the hope that the play would help 14-year-olds to quit smoking and discourage others from starting. In addition to the pupils, 150 teachers and 80 health professionals saw the play during a three-week run during January and February.

The play tells the story of Adam O'Reilly, a typical 15-year-old schoolboy with two loves in his life – smoking and the new girl Hayley Eve. The smoking message is tucked away in a love story, but all is revealed at the climax of the drama when both clash head on with tragic consequences for Adam.

The Smoke Free Oldham Campaign is supported by businesses and workplaces in Oldham, including local pharmacies, and many have already banned smoking ahead of July's legislation, which will make all enclosed places smoke-free.

Entry forms for Nucare golf tournament

It's time to start practising your golf swing as Nucare has once again teamed up with Teva and Actavis to organise its annual golf tournament.

Open only to Nucare members, the tournament comprises three regional qualifying events at familiar and new courses across the country.

The competition tees off at Hever Castle Golf Club on May 16, followed by the Hellidon Lakes Hotel course in Daventry on June 13 and Mentmore Golf and Country Club near Leighton Buzzard on June 27.

The first six qualifying pharmacists from each event will go through to play in the final at Menzies Cambridge Hotel and Golf Club at Bar Hill, Cambridge on September 12.

Prepare yourselves to take the tournament title away from last year's winner, Paresh Patel of Singlewell Pharmacy, Gravesend.

Entry forms are available by calling Michelle Spencer-King at Nucare head office on 01908 423500.

Pharmacists run for charity at London Marathon

Pharmacists are putting on their running shoes and pounding the streets in their spare time to get in training for the London Marathon on April 22.

This will be the first marathon for Hugh Apperley, a pharmacist at Lloydspharmacy in Barnstaple, but he is no novice at running as he belongs to North Devon Road Runners.

Although he's at a busy pharmacy that offers a number of services, including MURs, EHC and supervised consumption of methadone, Mr Apperley finds time to run home from work two to three times a week and fits in a long run at the weekend.

He is raising funds for Action Aid, a charity that he and his family have been supporting for several years. Contributions can be made at www.justgiving.com/hughcapperley

Gordon Farquhar, above, head of commercial at Co-operative Pharmacy, is also a first-timer in his attempt at running 26.2 miles, although he has completed several half marathons, including the Great North Run.

He hopes to raise money for The Children's Society, the Co-operative Group's chosen charity for 2007. He's also collecting sponsors at www.justgiving.com/gordonfarquhar

Counterpart winner keeps in the groove

Pharmacy assistant Stevie Keynes, of Regent Pharmacy in Gravesend, Kent, won a bottle of champagne in C+D's December 2006 Cambridge Counterpart draw, sponsored by Wyeth.

Ms Keynes, who is a student, works part-time as a PCA and has been at Regent Pharmacy for the past nine months. She likes the fact that the job allows her to work flexible hours to fit around her studies. In her spare time she enjoys dancing, particularly contemporary/street dance, and listening to music.

Ms Keynes, above left, is pictured receiving her bottle of bubbly from Sarah Smith, Wyeth's territory manager.

Appointments

The Welsh Pharmacy Board of the Royal Pharmaceutical Society has elected Peter Jones, left, as its chairman. Marc Donovan, right, takes up the position of vice-chairman.

Karen Acott, a pharmacist partner at the Wallingbrook Health Centre in Devon, has been elected as chairwoman of the board of the Faculty of Prescribing and Medicines Management, succeeding Steve Morris.

Robyn Hughes has joined generics manufacturer Teva UK as director, Teva Hospitals. He joins the firm from sanofi-aventis, where he was head of marketing.

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CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION - UK. Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusis, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW. J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6.** CHAMPIX Summary of Product Characteristics.

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